PCS Program Changes

PROPOSAL

October 2009

Why Change Now

- The program has grown from a cost of $3M in 2000 to $65M (after the budget cuts) in 2009.
- Average cost per recipient showed a 23% increase from 2002 to 2008.

Why Change Now

- There are reported problems with the current need assessment process
  - Inconsistencies among assessors' findings due to :
    - inability to complete any hands on physical/functional evaluation
    - no professional training in functional skill analysis (as physiatrists and therapists have).
  - Individuals calling FHSC for assistance with homemaking and reporting they do not need assistance with basic self care.
    - When FHSC informs them they are not eligible for homemaking assistance without self care needs, they call back a few days later, reporting self care needs.
  - PCS agencies coach recipients to identify assistance needs at levels above those that exist
  - PCS agencies approach families who care for their loved one out of family obligation and inform family members who meet provider qualifications that they could be paid to do the function, growing the program when there may be no need for the paid services to be provided.

Surveillance and Utilization Review Findings

- Time that has been allocated appears not to be needed, demonstrated by:
  - Recipients signing timesheets when the PCA hasn't performed the service, then the two split the money.
  - PCA submits timesheets for services not performed (PCA shopping/banking/elsewhere when other PCA tasks documented as taking place in the home)
  - Agencies fixing employee files and timesheets prior to scheduled audits.
  - PCAs billing service while incarcerated.
  - Recipients being coerced to lie and say that the PCA is not their spouse, when they are.

Surveillance and Utilization Review Findings

- Other issues identified not directly related to needs determination but that are quality issues:
  - PCAs with positive criminal backgrounds providing care.
  - Forged CPR cards and TB tests.
  - PCA billing service while recipient is in the hospital.

Why Change Now

- At the same time, state revenues are down and Medicaid enrollment and costs are up, leaving less money for optional programs.

The risk of across the board changes or loss of the program is real, unless substantial change is made.

Change Goals

- To ensure the program operates in a fiscally sound manner and prudently utilizes tax dollars to maintain this necessary service .
- To control program costs through accurate determination of need (vs. want)
- Eliminate the need to make across the board program reductions (as done in the September 2008 budget cut) for recipients of all need levels.
- To maintain this optional Medicaid service in this time of state revenue shortfalls.

Phase 1 - Change program from Social Model to Medical Model

FROM	TO
• In home interview • Complete by a RN or Social Worker	• In clinic “hands on” evaluation of functional abilities, followed by an in home evaluation for adaptive equipment and resources • Under the medical direction of a physiatrist, completed by an OT or PT

Phase 1 - Change program from Social Model to Medical Model

- How do we think these changes help?
  - OT/PT assessors, trained in functional skill analysis and disability care will evaluate “medical necessity” with final say and quality assurance completed by the physiatrist.
  - Recipients who do not have a need might be less likely to ask for a professional hands on assessment in a medical/clinic setting.
  - PT/OT assessors, can use clinical judgment to time limit authorizations, when appropriate.
  - Equipment needs will be assessed by the skilled professional. Having correct equipment in the home may reduce or eliminate the need for PCS.

Phase 1 Medical Model

FROM	TO
• Determined maximum hour limit for each ADL/IADL applied to the service provision of the ADL/IADL tasks • Request re-evaluation anytime (when do not like outcome of last evaluation)	• Determined maximum hour limit applied to overall program provision (hours) allowing flexibility in the ADL/IADL tasks based on recipient request/need at that time • Refine requirements to request re-evaluation to be based on medical issue requiring medical documentation of functional change

Phase 1 - Change program from Social Model to Medical Model

- How do we think these changes help?
  - Provide flexibility to meet daily needs, i.e. if recipient is ill and does not want shower, but needs extra laundry due to incontinence, may adjust how hours are used to meet daily fluctuations in needs. (Increased control over services)
  - Control re-evaluation process and expense, to require the process be based on an actual status change.

Phase 1 Medical Model

FROM	TO

• State Waiver Staff complete PCA functional assessment for waiver recipients	• State staff will assist waiver recipients to:
	  ◦ Obtain functional assessment
	  ◦ continue to monitor needs
	  ◦ provide case management linkages
	• Time freed by no longer completing functional assessment will be utilized for:
	  ◦ Provider oversight/audits,
	  ◦ Training
	  ◦ Program quality assurance
	  ◦ Activities outlined in plans of correction, etc.

Phase 1 – Where do we go from here?

- Refine program model (public workshops/hearings, SPA, Policy)
- Map current process to determine all operational steps that will remain or need revision.
- RFP to acquire program Medical Director contract
- Evaluate provider payment, recruitment, training
- MMIS system/process changes
- Implementation, evaluation of program changes, identification of issues, and program improvement

Phase 2 Considerations

- Further program improvements for possible implementation
  - Minimum threshold or need requirement for program entry
  - Provider/service tracking system
    - Provider registry (billing tracking)
    - Interactive Voice Response System (IVR)
    - Bar Code
    - Harmony, Consumer Empowerment System (CES) or other software

Concurrent Work Activities

- Program Change Time Line
- Program/Policy Development
  - Scope of Work for Medical Director to provide program oversight and quality
  - Provider qualifications/rates/payment process/referral
  - Functional Assessment directions/hours determination
  - Development and implementation of provider training on program rules
  - SPA/Chapter
- Determine Operational Changes
  - Current process flow for State Plan only and waiver - ID processes that need to change and develop operational steps and policy
  - MMIS and System Issues
- Stakeholder Issues
  - Input (recipient/provider /stakeholder workshops)
  - Provider training and enrollment (marketing to locate interested providers)